Maryland's State Healthcare Innovation Plan
Summary of Key Comments

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INTRODUCTION

The State Healthcare Innovation Plan was posted on the Maryland Department of Health and Mental Hygiene's (the Department) website for public comment from April 1, 2014 through April 15, 2014. The deadline for comments was extended until April 28, 2014 in order to provide all interested parties with sufficient time to review the State Healthcare Innovation Plan (Innovation Plan). The Maryland State Innovation Model (SIM) Team received 46 comments in total, 10 from state and local government agencies and 36 from external stakeholders. Thirty-eight organizations and individuals gave the Department permission to make their comments available to the public, which are posted on the Maryland SIM website. The comments are summarized below in 28 topic areas.

The Department is grateful to those who contributed their comments, and we appreciate the instructive input and time spent. All comments were closely examined. Many of the comments received have been incorporated into the response to the Funding Opportunity Announcement the Department will be submitting to the Centers for Medicare and Medicaid (CMS) for Round Two of the State Innovation Models grant (#CMS-1G1-14-001) by July 21, 2014.

TOPIC 1: CARE COORDINATION

Comment: The goal should be to build a system for population-based health, reduce disparities and improve health and wellness outcomes. This population-based model will lead to improvement in both public health goals and economic/fiscal goals.

Response: *The Department agrees. The concept behind SIM is to improve the health of individuals as well as populations. A systematic focus on the support for primary care is critical to improving outcomes for the entire population. Focusing on the super-utilizers will address disparities as the factors that contribute to their high health care utilization, which also tend to be the same factors that result in disparities.*

Comment: The metrics noted related to Community Health Hubs (CHHs) do not include metrics related to connection to social services. Are connections to social service benefits included in the metrics? Are there plans to track connections to social services?

Response: *This type of patient level data is part of the data integration efforts to follow patients across systems, part of the evaluation of the return-on-investment (ROI), is part of the CHH performance monitoring/measures and can be part of the Learning System (LS) core data components to measure effectiveness of each intervention.*

Comment: Many of the medically complex Medicare fee-for-service (FFS) and dual-eligible patients also have behavioral health (BH) issues. The path of referral to the CHH is unclear if they are not hospitalized. A social worker or community health worker (CHW) can assist the hospital emergency department with an assessment of needs and care plan that will connect the patient to the social services. A community organization focused on engagement of the client may be better able to get the supports that they need. Systems changes within governmental agencies outside of healthcare maybe necessary in order to serve this population.

Response: *The Department agrees. Addressing the full range of needs of patients is the hallmark of the community-integrated medical home (CIMH) model. Community-based organizations may be identified by the CHH as the most appropriate community-based service provider for this population.*

Comment: It is recommended that a coordinated care model be implemented for BH consumers. The CIMH reflects the recovery model, which employs community supports and peer support specialists trained in working with individuals in recovery from a mental illness or a substance abuse disorder (SUD).

Response: *Patients will be connected to the most appropriate service with care coordinated through the CHH that includes care coordination and integration through data sharing and integration. This is the foundation of the CIMH model.*

Comment: The Innovation Plan does not reference the pending BH Home and 1915(i) State Plan Amendment (SPA) and does not speak to how the SPA will be incorporated into care coordination for youth with BH needs and their families. Details on the Health Home SPA is available at: http://the Department.maryland.gov/bhd/SitePages/Health%20Homes.aspx

Response: *The Chronic Health Home SPAs has been enrolling individuals and providers since late 2013 (see http://dhmh.maryland.gov/bhd/Documents/HealthHomesReport_December2013.pdf). Medicaid enrollees with BH needs who are in need of enhanced services and are not seen by a Medicaid Chronic Health Home provider will be referred to the CIMH under the SIM. The 1915(i) anticipates enrolling children and adolescents with serious emotional disturbance. 1915(i) services will be provided only to qualified individuals with the accessibility or intensity of currently available community supports and services are inadequate to meet the individual's needs due to the severity of his/her impairment. Children and adolescents not enrolled in the 1915(i) will be referred to the CIMH under the SIM.*

Comment: There is an assumption that registered nurses (RNs) will be used to clinically coordinate care in the community. Typically, RNs are not trained to provide the intense "out in the community" interventions and are not trained outside of the clinical care coordination model.

Response: *Health Quality Partners' (HQPs) model has been very successful within the Medicare population and relies heavily on nurses to provide very intensive community-based clinical care coordination. Towards that end, we believe nurses have a critical role in the CIMH model. Many types of nurses (e.g. public health nurses and home based nurses) have this type of community-based training, but we do not believe nurses can do this alone. For that reason, we have described efforts underway to expand the CHW workforce to expand the reach of nurses and ensure that all health professionals can work at the top of their license.*

Comment: The role of the RN and other health care professionals is not discussed. Also, how does other health care professionals (e.g. certified nursing assistants and certified nurse med techs) fit into the model related to the services ascribed to the CHW and the extent to which they already provide, or may be trained to provide, the services foreseen for CHWs? There is also no discussion of other licensed health care professionals.

Response: *The full staffing model of each CHH will ultimately depend on the target populations served. CHHs will have flexibility in pulling together the right blend of skills and expertise, including nurses, CHWs, and other health care professionals like nursing assistants. It is important to clarify that the CHW*

role does not usurp the role of RNs to provide clinical care coordination but rather the CHW role augments the services provided by a variety of health care professionals.

Comment: What is the evidence to support constructing a statewide external care coordination system (rather than embedding the care coordinator in the practice)?

Response: *The HQP model is an example of a successful "unembedded" care coordination model that has been very effective within the Medicare population. This model relies heavily on nurses to provide intensive community-based clinical care coordination. These nurses work very closely with their patients' primary care providers (PCPs) and in some cases, those practices may have embedded care coordinators.*

Comment: The Innovation Plan should be revised to support the capacity of PCPs to provide care coordination services.

Response: *Providers currently providing care coordination services may continue to do so under the SIM model. The intent of the CHHs is to extend the reach of the primary care practice to more effectively coordinate care.*

Comment: We are supportive of ensuring there is support for care coordination at the provider level, we recognize that not every provider will have the capacity for comprehensive care coordination. Therefore, we would be deeply interested in continuing the discussion about which circumstances would warrant external care coordination.

Response: *The Department agrees and would welcome the continued discussion.*

Comment: What is the evidence to support the statement that the target population "typically receives poor quality care"? Federally Qualified Health Centers (FQHCs) are currently providing high quality care.

Response: *For this target population, outcomes lag behind performance measure benchmarks. Community-based wraparound services still need to improve care delivered to the most needed populations who may or may not be served by any health care professional, including a FQHC. The CHH will augment current FQHC activities and improve outcomes among all FQHCs.*

Comment: The Department needs to make sure there is coordination without duplication of care coordination services from CHWs and other care coordinators across systems. A flow chart or graphic depicting various anticipated/projected hand offs across systems, with distinction between care managers and CHWs [would be helpful].

Response: *The Department agrees. Each CIMH will develop an agreement with the CHH that includes roles and responsibilities to avoid duplication. The CHH will take into account the other care coordination services available to each patient and a single care coordinator role will be designated.*

Comment: Regional implementation teams using implementation science are recommended to ensure information sharing and course correction if needed.

Response: *Data sharing for improved care and care coordination is a hallmark of the SIM model. Data integration efforts will facilitate data sharing and use data for evaluation of program outcomes as part of the LS.*

Comment: State coordination is needed and must translate into local coordination activities for effective care coordination. This is particularly true for those systems that have more local control rather than state (e.g. school systems).

Response: *Data sharing is a critical part of translating to the local level.*

Comment: The information on care coordination in the plan is not accurate. There are specific care coordination programs that are not mentioned (Community Options Waiver and the Community First Choice Program). The report should be expanded to include these programs. Adding another layer of care coordination may be confusing.

Response: *Each CIMH will develop an agreement with the CHH to include roles and responsibilities to avoid duplication. The CHH will take into account the other care coordination services available to each patient and a single care coordinator role will be designated. Any available programs will be considered at the patient and community level.*

Comment: Since only 50% of the PCPs in Maryland participate in the patient centered medical home (PCMH) model, we suggest that an incentive for participation be included to increase that percentage. Incentives should support the reduced utilization of psychiatric hospitalization for those with BH issues. This incentive should incorporate the use of a community-based care coordinator or CHW that engages the member or client with targeted support from the PCHM team that connects the consumer and their family to mental health and substance abuse services in their community.

Response: *Maryland's PCMH/CIMH program flexibility and lightened burden to participate is the incentive for participation while recognizing practices currently participating in a PCMH program. Also, by its nature, the CHH allows providers to focus on clinical activities necessary, including BH activities, to achieve good patient outcomes.*

Comment: Care coordination payments should be linked to activities that a practice should perform or measurable results that show that the care coordination is effective. Care coordinators should not be funded without having periodic performance measurement.

Response: *The payment model for the community-based wraparound services and supports will be a capitated payment based on the cost of the intervention, based on meeting agreed upon quality and performance targets. By basing the per capita payments on cost, this global budget approach ensures that CHHs will have adequate funds to provide the care these patients need. At the same time, by capping total payments, CHHs will be appropriately incentivized to use these funds efficiently.*

TOPIC 2: COMMUNITY HEALTH HUBS

Comment: CHHs should include Local Health Officers (LHOs) and local health departments (LHDs) as the central component, and the LHO should determine if the LHD or the Local Health Improvement Coalition (LHIC) should be the CHH or if there should be a competitive process for their communities.

Response: *CHHs will be selected through a competitive request for proposal (RFP) process to allow local assets to apply for this role. The Department acknowledges that the LHO and LHD have considerable*

public health expertise and resources to contribute to the CIMH program, which should be leveraged where possible along with other resources available in the community.

Comment: There is concern about the CHHs developing strong relationships and systems to assure that the appropriate patients are referred and that strong coordination with the provider care delivery team is established. The CHHs also need to be viewed as a neutral party in order to develop and sustain relationships.

Response: *CHHs will be selected through a competitive RFP process to allow local assets to apply for this role. Organizations eligible to apply as a CHH will include: LHDs, LHICs, hospitals, community-based 501(c)(3) organizations, and collaborative partnerships between these entities. In some communities the LHIC and CHH will be one in the same, but where this is not the case the LHIC and CHH will work together to ensure alignment with community identified priorities and strategies and to track and monitor progress.*

Comment: There should be support to develop the CHH with more than a case rate payment due to the limited capacity to serve this population and coordinate with Baltimore City Hospitals. There are many moving parts in Baltimore city and the cost of this administrative oversight may well be 10% or more of the cost of a case rate.

Response: *If awarded SIM testing dollars, CHHs will be financed on a capitated severity-adjusted "case rate" basis, based on what it costs to deploy the set of interventions appropriate for their specific target populations. Capitated payments will promote efficiency among CHHs while also providing the necessary flexibility CHHs will need to tailor the set of services to the needs of each patient served. Pricing will also be a la carte so that payers who opt to "pay and play" can select which services they would like to purchase from the menu of services and supports and only pay for those items their patients utilize.*

Comment: Functions of the CHH and LHICs seem duplicative. PCMHs, Chronic Health Homes, and LHICs may be better suited to coordinating patient care than a CHH.

Response: *CHHs will be established by an organization or coalition of organizations best suited to deploy the community-based wraparound services. In some cases the LHIC and the CHH may be one in the same. However, LHICs with less experience coordinating services across sectors and geographies may not be able to fulfill the broader CHH responsibilities of coordinating and deploying the community-based wraparound services.*

Comment: What authority/leverage will CHHs have over others, such as over hospitals? Who can make ultimate decisions? And, do CHHs report directly to the state?

Response: *Hospitals will be eligible to apply to serve as the CHH for their communities. For some communities, therefore, the CHH and the hospital may be one and the same. Additionally, several LHICs are co-chaired by LHDs and hospitals. Where these LHICs are selected to serve as CHHs, hospitals will play significant leadership roles within their CHHs. Where either of these scenarios is not the case, the CHH will interact closely with hospital discharge planners to facilitate and support care transitions. Where there are outpatient programs offered by the hospital to the community, the CHHs will ensure that those are part of the inventory of community resources so that the CHH can link patients to those resources where appropriate. Finally, when hospitals identify patients who they believe would benefit from receiving wraparound services and supports, hospitals will be able to refer patients to the CHHs.*

The effectiveness of the CHH will be measured by the Public Utility that will be overseen by the Department and the Maryland Health Care Commission (MHCC).

Comment: The staff in the CHHs will make the difference between success and failure, and passion and a true commitment to the community being served can be more valuable than credentials. For this reason, the Department might consider including additional points in the CHH RFP for proposals that commit to employing staff from the served population.

Response: *The Department agrees. The CHH will be primarily accountable for service quality, effectiveness, and efficiency. With these goals in mind the CHH may directly hire, train, manage, and deploy staff from the community that are required to implement the community-based wraparound services or it may contract with other resources in the community capable of providing such services.*

Comment: How will the State roll out the CHH grants? Will three CHHs be selected first, then six months later another three? Will six CHHs be selected at first, with three in the Model Testing phase and three in the Pre-Testing phase?

Response: *Implementation of CHHs will be phased in and based on the readiness of the CHHs.*

Comment: What happens in the event that there is not an entity that applies to become the CHH?

Response: *CHH will be selected through a competitive RFP process. Applicants that can demonstrate a history of strong and effective community-clinical linkages that have led to improved population health will be provided priority consideration. Where there is not an appropriate entity to apply to become the CHH in a specific community there may be opportunities to collaborate with partners across the region.*

Comment: The LHICs are charged with maintaining a "comprehensive and up-to-date inventory of resources, services and current contacts for the CHH to access in coordinating care for their patients;" it is suggested that this task might be better undertaken by a "boots on the ground" organization.

Response: *Through the CIMH framework, the LHICs will continue to work with partners across the community with the goal of improving health outcomes. LHICs will continue to be the entity in the community chiefly responsible for convening stakeholders, planning, prioritizing, aligning strategies, and tracking population health outcomes. It is conceivable that the LHIC could collaborate with existing organizations to develop and maintain the inventory of resources as part of the LHICs work.*

Comment: How would the work of the CHH's intersect with the Community First Choice program in which seniors (Medicare and dual-eligible) also get home visits, home-based personal care and nurse monitoring home visits?

Response: *All CHHs will be required to address the needs of Medicare FFS and dual-eligible patients.. CHHs applicants will be required to describe how they will provide wraparound services to the Medicare FFS and dual-eligible populations in their jurisdictions. Depending on the geographic area of the state the programs and resources will be different. Existing programs and resources should be inventoried by the LHIC and leveraged, integrated, and possibly expanded when appropriate by the CHH to avoid duplication.*

Comment: As the financial model is prepared for the Innovation Plan, we recommend that compensation of the CHH should provide the CHH with the ability to recruit, hire, train, manage performance, and retain trained hires for this work. The human capital necessary to provide these services (i.e. CHWs) that are relationship heavy and are specific knowledge and skill sensitive are human resources not readily available and difficult to continually replace due to turnover. We suggest that a CHH be given the opportunity to adjust salary and provide incentive-based payment structures for high performance teams in order to maintain the ability to achieve the results that the Department is seeking. A shared savings payment structure should also be made available to CHHs who achieve or exceed anticipated results or outcome targets.

Response: *The payment model for the CHH will be a capitated payment based on the cost of the intervention and on meeting agreed-upon quality and performance targets. Moving away from a FFS payment model will provide CHHs the flexibility they will need to recruit, hire, train and manage performance of staff based on the interventions deployed.*

TOPIC 3: COMMUNITY HEALTH WORKERS

Comment: Organizations engaged in training CHW should be allowed an opportunity or participate in the curriculum development or pilot for CHWs. How will existing CHW programs and CHWs be grandfathered in to the new curriculum?

Response: *The Department agrees. The Department has partnered with Maryland's community colleges and has requested their assistance in drafting CHW curriculum standards based on the information provided in the SIM plan, and the existing evidence base of CHW curricula from Ohio, Minnesota, Texas, and New York. The Department will build on the experience of organizations across the state already engaged in the development and implementation of CHW training programs. These organizations include the Health Enterprise Zone (HEZ) grantee, hospitals, universities/community colleges, Area Health Education Centers, Minority Outreach and Technical Assistance grantees, and some LHDs.*

Pursuant to Chapter 259 of the Acts of 2014 (House Bill [HB] 856), the Department will establish a Workgroup on Workforce Development for Community Health Workers (CHW Workgroup) to help guide the development of a statewide CHW certification and training program. The CHW Workgroup will include: CHW content experts (academic and lay people), CHW employers (hospitals, clinical providers, health systems, LHDs, and community based organizations), CHW representatives, and consumers of CHW services. As part of their work, the CHW Workgroup will make recommendations on whether or not to grandfather in certain programs in the short term while developing a long term plan to move towards one statewide curriculum under the community colleges and other eligible organizations that might still be deemed as sites to provide CHW training.

Comment: Practicing care coordinators working in a capacity equivalent to the CHW should be grandfathered in or have an opportunity to "test out" to acquire certification. Continuing education should also be necessary to maintain certification on an annual basis.

Response: *Pursuant to Chapter 259 of the Acts of 2014 (HB 856), the Department will establish the CHW Workgroup to help guide the development of a statewide CHW certification and training program. The CHW Workgroup will include: CHW content experts (academic and lay people), CHW employers (hospitals, clinical providers, health systems, LHDs, and community based organizations), CHW representatives, and consumers of CHW services. As part of their work, the CHW Workgroup will make*

recommendations on whether or not to grandfather in certain programs in the short term while developing a long term plan to move towards one statewide curriculum under the community colleges and other eligible organizations that might still be deemed as sites to provide CHW training.

Comment: There is a gap related to CHW education in courses on the supervision of CHWs. To build a workforce, which is somewhat unique in its characteristics, but not to build the skills for supervising and leading such a workforce, would be counterproductive.

Response: *The role of the CHW supervisor is critical in the CIMH framework. The CHW Workgroup, as established by Chapter 259 of the Acts of 2014 (HB 856), will look at the role and competencies of CHWs and CHW supervisors, also necessitating the development of competencies and training for supervisors.*

Comment: How does the proposed certification compare to the existing public and community health programs offered? What level is the proposed certification?

Response: *The Department will establish the CHW Workgroup to help guide the development of a statewide CHW certification and training program. The CHW Workgroup will be a group of cross sector CHW experts that will provide recommendations on the CHW role and function, curriculum standards, standards to monitor and evaluate the program, and requirements of organizations and institutions that provide CHW training such as community colleges and other eligible institutions or organizations. The CHW Workgroup will help determine the level of the proposed certification.*

Comment: There is considerable overlap between the CHW functions and core competencies and those with a Bachelor's degree in Social Work (BSW). We strongly encourage that the development of the CHW role and training program be carried out in conjunction with BSW programs located within the State.

Response: *The CHW role as envisioned in the CIMH framework will require skills to identify patient needs, support individual linkages to clinical and non-clinical services, advocate for patients and their families, and interface effectively with both clinical and non-clinical providers. These key functions and the core competencies associated with them are provided in the Innovation Plan. CHW education will not be as advanced or as comprehensive as social workers.*

Comment: There must be a reimbursement source to grow jobs for these CHWs upon certification.

Response: *Chapter 259 of the Acts of 2014 (HB 856) requires the Department and the Maryland Insurance Administration (MIA) to establish the CHW Workgroup to study and make recommendations regarding the training and credentialing for CHWs and reimbursement and payment policies for CHWs through the Maryland Medical Assistance Program. These recommendations will be reported to the Maryland General Assembly by June 1, 2015. Recommendations from the CHW Workgroup will provide guidance on reimbursement for CHWs.*

Comment: The need for bilingual, bi-cultural or representation of racial and ethnic populations among CHW graduates should be considered when building these programs.

Response: *The Department agrees. Core competencies of CHW training include: develop and disseminate culturally and linguistically appropriate information to clients as outlined in joint team/client plan regarding available services and processes to engage in services; and communicate effectively with patients and families in a culturally competent manner.*

Comment: A new category of CHWs with independent certification should provide for additional opportunities and not replace existing BH providers including social workers, licensed professional counselors and certified addiction counselors.

Response: *The Department agrees.*

Comment: The Innovation Plan references CHWs doing some direct care services under the supervision of a licensed clinician, nurse, or social worker. Each health occupation has a scope of practice strictly defined and set out in statute and regulation as well as laws on unlicensed practice. Delegation authority is not something that can be done without express authority being granted in statute.

Response: *Chapter 259 of the Acts of 2014 (HB 856) requires the Department and MIA to establish the CHW Workgroup to study and make recommendations regarding the training and credentialing for CHWs and reimbursement and payment policies for CHWs through the Maryland Medical Assistance Program. These recommendations will be reported to the Maryland General Assembly by June 1, 2015. Recommendations from the CHW Workgroup will provide guidance on core competencies, scope of practice and supervision for CHWs.*

TOPIC 4: COMMUNITY-INTEGRATED MEDICAL HOME ADVISORY BODY

Comment: It will be important to ensure rural representation from rural LHICs and LHDs in the Community-Integrated Medical Home Advisory Body (CIMH Advisory Body).

Response: *The Department agrees.*

Comment: Will the Community Health Resources Commission be an active participant in the CIMH Advisory Body process?

Response*: Yes.*

Comment: Nursing should be well represented on the CIMH Advisory Body. Only one nurse representative was included in the SIM stakeholder panels.

Response*: The Department agrees.*

Comment: The Boards should be part of the CIMH Advisory Body.

Response: *The Department agrees.*

Comment: The CIMH workgroups should include representation of organizations that work with children's systems and transition-aged youth and should include family members and youth, as well as policy makers and providers, depending on the purpose of the groups.

Response: *The Department agrees.*

Comment: We recommend that representatives from university-based schools and departments of social work and BSW programs be included in the Workgroup on Workforce Development for CHWs.

Response: *We plan to release a Request for Applications (RFA) shortly to gauge interest in participating on the CHW Workgroup. While we are required to stay within the broad parameters of the state law and ensure adequate representation from multiple stakeholders and perspectives regarding the composition of the Advisory Body, we agree that university representation would be beneficial and encourage universities and departments to submit an application through the RFA process.*

Comment: The Department should remain open to soliciting comment and feedback through the CIMH Advisory Body.

Response: *The Department agrees**.** We welcome feedback and remain open to refining the Innovation Plan in light of comments received. The Innovation Plan is meant to be a "living document" and stakeholder engagement will continue.*

TOPIC 5: COMMUNITY-INTEGRATED MEDICAL HOME TEAMS

Comment: Developing protocols for this new extended team in CIMH that still supports the provider will be essential.

Response: *HQP, who provides content expertise related to population health strategies in general and on the use of the advanced preventive service (APS) model, report that using fairly simple communication and coordination protocols with PCPs, health systems, post-acute providers, and insurance plans has ensured complementation of care services.*

Comment: Deploying Community Health Teams (CHTs) in a way that integrates with current activities would build on relationships that already exist between providers and LHDs. Because the working relationships between providers and LHDs are not uniform across jurisdictions, a uniform approach to integration is not likely to be well accepted.

Response: *The Department agrees. CHHs will identify the organization or coalition of organizations best suited to deploy the community-based wraparound services in their jurisdiction or region. CHHs will be selected through a competitive RFP process to allow local assets to apply for this role and in some cases LHD's may assume this role. The CHH will work with the LHIC to engage community partners to provide policy and system solutions to eliminate barriers or fill gaps.*

Comment: What metrics will be used to measure the work of CHTs?

Response: *Developing a core set of metrics was a major goal of the SIM Model Design process. The four major criteria for measure selection are:*

- *Minimal administrative burden for provider reporting*
- *Utilize metrics already being reported*
- *Endorsed by national consensus organization*
- *Linked to evidence and Meaningful for Maryland*

Based on these criteria, several candidate metrics were identified (though consensus was not achieved). The Department will continue to work with the CIMH Advisory Body and the payers in the State to reach a consensus on the core set of metrics and the staging of those metrics.

Comment: Is pediatric care to be included in all phases of this process, and it is critical that this be explicitly stated in the plan.

Response: *Pediatric care is included in the Innovation Plan's asthma example. Children will be included in CIMH if they meet the "super-utilizer" definition. Young adults and children ages 20 and below comprise 5% of the super-utilizers in Maryland.*

Comment: The role of nurses is insufficiently addressed or integrated into the model. Although the nurses play a central role in the HQP concept, the Innovation Plan focuses almost exclusively on CHWs. There needs to be increased focus on RNs and other licensed health care practitioners.

Response: *The Department agrees. The CHH and CHT concept is informed by the HQPs APS model. The CIMH is a team-based model in which nurses and other licensed health care practitioners will make a full and important contribution.*

Comment: The structure of staffing of care teams, supervision requirements and financing of the team are not addressed.

Response: *The target populations served by the CHH and the services they will ultimately deploy determine the full staffing pattern at each CHH. A CHH may directly hire, train, manage, and deploy staff required to implement the community-based wraparound services or it may contract with other resources in the community capable of providing such services. The payment model for the community-based wraparound services and supports will be a capitated payment based on the cost of the intervention, paid to the CHHs based on meeting agreed upon quality and performance targets.*

TOPIC 6: COMMUNITY PARTNERS

Comment: The CHH model does not take into account community assets and the importance of shared leadership when developing innovative programs for communities. In order for the Innovation Plan to succeed, there should be an assessment of community assets, needs and preferences that reaches for input to a range of community organizations and individuals.

Response: *The CHH model recognizes that effective partnerships with local community assets will be critical for meeting financial and quality improvement goals. The LHIC will work as the integrator and be responsible for bringing partners together to address gaps in care with community partners and having a comprehensive and up-to-date inventory of resources, services and current contacts for the CHH to access. Also, Maryland's LHDs have extensive experience working with community partners to deploy public health interventions that are essential to the CIMH model.*

Comment: The development of true networks of care supported by clear strategic alliances with the CHHs will be essential for success (BH and critical support services).

Response: *The Department agrees. The CHH will need to work closely with PCMHs within their communities and regions to deploy CHTs and wraparound services to identified individuals in the target*

population. However, the need for community-based clinical care coordination in the Maryland context will differ across the state based on geography and the availability of existing services, resources, and access to primary care. The CHH will develop agreements with PCMHs participating in the CIMH model and agree upon the scope of clinical care coordination services provided by CHTs. This tailored approach is important to meet the specific clinical needs of the individual, but also to align clinical services provided to the patient to prevent duplication of effort. The CHH and PCMH will work together to ensure that BH and critical support services are included.

Comment: The Department intends for the social service branch of the State, the Department of Human Resources, to assume the responsibility for providing the social services component of the model either through direct services or referral to the already over-extended, existing community social service providers who are already suffering from limited funding. In addition, it is not clear that these agencies would even have the capacity to increase their services.

Response: *Maryland CIMH will adapt lessons learned from Hennepin Health in Minnesota and the Vermont Blue Print for Health regarding the integration of social services for high-utilizing patient populations.*

TOPIC 7: CONSUMERS AND STAKEHOLDERS

Comment: How will the Innovation Plan incorporate consumer choice, continuity of care with current providers, shared decision-making and self-directed care? How and when will consumers opt-in or opt-out of the model?

Response: *Building a truly patient-centered health care system is the intent of the CIMH. Continuity of care will not be affected under SIM: patients can choose which PCPs they would like to see, consistent with their health plan requirements. Only those patients who agree to participate in the CIMH will receive the community-based wraparound services and supports. We anticipate that roughly one out of every four patients we outreach to will choose to enroll.*

Comment: The two stakeholder groups were limited and restricted; the limitations made it difficult for advocates to participate. The Department's Health Systems and Infrastructure Administration (HSIA) should look to the Health Services Cost Review Commission (HSCRC) process on the Medicare waiver to ensure an informed, open, and deliberative process.

Response: *While no further meetings are planned before the submission of the Model Testing Design to the Centers for Medicare and Medicaid Innovation (CMMI), the Department anticipates additional opportunities for stakeholder comments through the CIMH Advisory Body.*

Comment: The proposal lacks a mechanism to address consumer complaints.

Response: *The Department agrees. SIM anticipates developing a process by which the public would be informed about the new delivery system and data sharing. As part of that public education, we anticipate working with the Attorney General and providers to develop an informed consent process that fully describes the confidentiality protections and consumer complaint process.*

Comment: Demonstrate how physician practice efforts in this program tie back to practice revenue.

Response: *To incentivize performance improvement, a number of different types of value-based payments are already being used and will continue to be used. For example, primary care practices that participate in Maryland's Multi-Payer PCMH program are currently provided upfront payment for coordination as well as shared savings with quality improvement, essentially functioning as multi-payer private ACOs.*

For existing PCMH programs, payers with oversight from MHCC will continue to negotiate payments, bonuses, and other terms with PCPs. Likewise, payments will continue to be negotiated directly between CMS and the PCPs for Medicare Accountable Care Organizations (ACOs).

TOPIC 8: CORRECTIONAL SYSTEM

Comment: Children and adults who transfer from the correctional and juvenile justice system should be included in the CIMH to loss of continuity of care, periods of un- and under-insurance, and care fragmentation.

Response: *The Department agrees. Jail-involved individuals/out-of-home youth placements could be included, especially as many are high cost or super-utilizers of somatic and/or BH care.*

Comment: The SIM should include more on addictions treatment, including residential treatment for minors, tracking of Hepatitis C, and prevention of overdose deaths.

Response: *Prevention of overdose deaths is a major public health focus of the Department separate from SIM. In addition, access to treatment services for substance abuse users/abusers and tracking of Hepatitis C are also core to the Department's mission. SIM will leverage the Department's current initiatives for super-utilizers identified through a CHH.*

Comment: Inmates should have the same level of care as would be available in the community (Civil Rights of Institutionalized Persons Act). Workforce development and health infrastructure improvements should include the corrections health system, especially in facilities that serve juveniles.

Response: *Defer to Department of Corrections.*

TOPIC 9: EVALUATION

Comment: Evaluation efforts appear to be medically focused and do not integrate BH metrics or metrics that can measure patient satisfaction.

Response: *Developing a core set of metrics was a major goal of the SIM Model Design process. Several candidate metrics were identified, including BH and patient satisfaction metrics, but consensus during the stakeholder meetings was not achieved. The Department will continue to work with the CIMH Advisory Body and the payers in the State to reach a consensus on the core set of metrics inclusive of BH.*

Comment: The proposed patient experience of care measure does not address the consumer perspective in a comprehensive manner.

Response: *The Clinician and Group CAHPS survey is a nationally recognized patient satisfaction measure and is included in the set of patient satisfaction measures we anticipate using. If stakeholders believe there are better measures, we would be interested to learn more.*

Comment: There are not enough outcome measures for mental illness and SUDs. We encourage the state to work with BH community to determine what evidence-based BH outcomes can be assessed.

Response: *Developing a core set of metrics was a major goal of the SIM Model Design process. Several candidate metrics were identified including BH metrics but consensus during the stakeholder meetings was not achieved. The Department will continue to work with the CIMH Advisory Board and the payers in the State to reach a consensus on the core set of metrics, inclusive of BH metrics.*

Comment: Will the Public Utility have enough oversight responsibility and enforcement authority if it is not housed within a regulatory body?

Response: *The Department administers and oversees numerous programs: we do not believe it is necessary for the Public Utility to reside within a regulatory body. Rather, the main criterion for determining which entities would be appropriate to staff the Public Utility was based on existing expertise and infrastructure. MHCC – one of Maryland's regulatory bodies – will oversee the primary care-facing side of the Public Utility because of their deep experience with PCMH programs and administration of the all-payer claims database. The Department will oversee the community-facing side of the Public Utility, given its experience in administering the State Health Improvement Process (SHIP) and its lead role within the Department for population health improvement.*

TOPIC 10: FINANCIAL MODEL

Comment: The payment model is unclear and seems like a demonstration project.

Response: *If the Department receives a SIM Model Testing award, the CIMH will be implemented very much like a demonstration project. The proposed payment model for the primary care side of the CIMH would largely be left to payers and providers to negotiate between themselves, as is currently the case in the Maryland PCMH programs. The proposed payment model for the community health side of the CIMH will be a capitated payment based on the cost of the intervention, paid to the CHHs based on meeting agreed upon quality and performance targets. By basing the per capita payments on cost, this global budget approach ensures that CHHs will have adequate funds to provide the care these patients need. At the same time, by capping total payments, CHHs will be appropriately incentivized to use these funds efficiently.*

Comment: How does the payment model work for Medicaid Managed Care Organizations (MCOs)? Will payments be built into rates/budget? Who pays for non-MCO benefit costs?

Response: *The Department is planning on requesting grant dollars to pay for the services provided by the CIMH. At this point, the Department envisions that supplemental payments will be made to the CHH during the SIM Model Test period on behalf of the Medicaid MCOs for their enrollees who are referred to the CIMHs.*

Comment: How will savings be calculated? How will savings be attributed in a complex healthcare environment where multiple reform efforts are taking place simultaneously? How will savings be

redistributed through the grant period? Will there be efforts to calculate ROI throughout the grant cycle or only at the end of year 3?

Response: *The health services research around solving this question is in a relatively nascent stage, but the methodology we have proposed is consistent with current best practices. We anticipate that the LS proposed as part of the Innovation Plan will go very far in advancing the science around attribution of savings. Additionally, implementation of the CIMH will likely take place in waves. Some regions will be implementing the CIMH model while others will be in the planning stage, thus enabling quasi-experimental research designs will help to isolate the impacts of the CIMH relative to the Modernized Hospital Payment Model.*

Comment: Community organizations have been providing many of the types of services described in the Innovation Plan.

Response: *The CIMH is not a new intervention: it is best conceived as a flexible model or framework that will enable Maryland to coordinate, refine and expand services, supports, and delivery reform efforts so that they can build upon each other and create the synergies required to realize their full potential impact. The CHHs, will be responsible for deploying interventions with demonstrated effectiveness from a menu of community-based services and supports. We very much want to ensure that this menu is as comprehensive as possible and invite the community to send us more information about their programs for potential inclusion in this menu.*

Comment: When layering new programs onto existing ones, it is important to ensure that there isn't an unintentional increase in costs so that the new programs can be sustained without adding cost to an already expensive delivery system.

Response: *The Department agrees. We are encouraging the community to let us know about the innovative and effective service delivery models they are providing. We want to make sure that any existing programs that CIMH builds upon are themselves cost-effective, and that CHHs leverage those models so that additional SIM dollars can be reserved for filling critical community gaps.*

Comment: Community organizations that provide these types of wraparound services are often underfunded and the funding mechanisms in place limit them to certain criteria and restrictions in their work, which precludes them from delivering the full spectrum of services need to combat social determinants of health.

Response: *One of the limitations of our current health care system is the FFS method by which services are reimbursed and that limit the flexibility with which health care dollars can be spent. In the CIMH, we have proposed a capitated payment model for the community health side of the CIMH model. As long as CHHs stay within that budget, how CHHs use those capitated funds will remain flexible so that CHHs can deploy them to most efficiently meet the varied needs of the super-utilizers they are serving.*

Comment: Appropriate investments in information technology (IT), consumer education and engagement, and training at all levels will be required.

Response: *The Department agrees.*

Comment: The model requires a large number of contracts and agreements. Will funding be provided to pay for the additional staff positions that will be required to provide the necessary oversight functions?

Response: *The capitated case rate that CHHs will receive will include provisions for administrative, IT, and staffing costs. However, CHHs will be expected to partner with organizations and leverage existing resources within the community, including partnering with organizations with adequate infrastructure and experience to most efficiently execute contracts and agreements.*

Comment: How and when do CHHs get paid? Are there new billing codes associated with the CIMH? And what would be the claims submission and reimbursement process?

Response: *CHHs will get paid a capitated case rate. CHHs will need to demonstrate how many super-utilizers they are serving and will receive a payment for each patient. There will be no new billing codes associated with the community health side of the CIMH. The capitated payment model will provide CHHs the needed flexibility in providing the varied services that super-utilizers are likely to need.*

Comment: How will the capitated "case rate" be calculated?

Response: *It will be based on estimates of how much it will cost to provide the services. For example, it costs HQP $150-220 per person per month to provide its services, inclusive of staffing, IT, and administrative costs. At an average of $185 per person per month (or $2,220 per person per year), if HQP served 100 patients over the course of a year, they would receive $22,220 per year to serve those patients.*

Comment: Besides Medicare and Medicaid, is the CIMH model open to commercial health maintenance organizations, preferred provider organizations, and other MCOs?

Response: *Yes, the model will be open to all payers.*

Comment: We believe the CIMH model holds promise. However, for payers who already have developed programs in place, participation in the CIMH should be voluntary. It is too burdensome to expect payers to prove their existing programs have achieved an undefined benchmark by year 2, especially if ROI is not determined until after the 3 year grant period. Any benchmarks that are set for payer programs that are not part of the CIMH should likewise apply to the CIMH programs.

Response: *The Department agrees. Participation for payers who already have developed programs will be voluntary*

Comment: How will SIM interact with the waiver? How will the hospital savings through the waiver be shared?

Response: *Under the new waiver the growth rate for hospital payments are pegged to the rate of general inflation. The difference between the anticipated health care cost growth rate (i.e. if the waiver were not implemented) and that rate of inflation represents savings that payers will share. Hospitals that are successful under the new waiver and are able to constrain their costs below their global budgets while maintaining high quality care and improved patient outcomes will have discretion in how they share their additional savings.*

By 2017, Maryland will be required to submit to CMS a plan to move away from hospital-focused success tests (e.g. reductions in hospital-acquired conditions) to a total cost of care success test. SIM will allow us to test the CIMH model and bring it to statewide scale so that Maryland is ready when that total cost of care success test is imposed.

TOPIC 11: GOVERNANCE AND LAW

Comment: The Governance chart in the Innovation Plan is confusing. The chart makes it seem that the current governance and authority over HSCRC, CIMH Advisory Body, Medicaid Waiver, etc. will be under CIMH.

Response: *Current governance and authority of HSCRC, MHCC, Medicaid Waiver, etc. is not changing.*

Comment: In some places the Innovation Plan appears to give the CIMH Advisory Body authority over CIMH implementation, not the Department or the Public Utility. Likewise, in some places the Innovation Plan appears to give the Public Utility authority over MHCC, HSIA and certification authority over the CHHs.

Response: *Current governance and authority of HSCRC, MHCC, Medicaid Waiver, etc. is not changing. The Public Utility will provide oversight for CIMH implementation.*

Comment: Further consideration needs to be given to governance and authority to be efficient, transparent and consistent. Not doing so may impact implementation negatively.

Response: *A major component of the CIMH Advisory Body and the groundwork in the Department is to ensure CIMH is compliant with existing law, including governance and authority between and among all respective state entities.*

Comment: The Innovation Plan appears to present the proposal as certain, instead of a proposal. Extensive legislation is required for implementation of the Innovation Plan; the public expects all applicable stakeholders to be involved in creation of this legislation to make it meaningful.

Response: *The CIMH Advisory Body and workgroups will continue to engage existing and new stakeholders throughout the planning, pilot and expansion processes, including the creation of any necessary legislation. The Department and applicable state agencies are aware of the extent legislation is required.*

Comment: The Innovation Plan will require significant legislative work to ensure scope of practice and licensure with nurses is not violated, thus compromising patient safety. Patient safety should be the forefront of CIMH/SIM.

Response: *Chapter 449 of the Acts of 2014 (HB 1235) establishes the CIMH Advisory Body, which provides overarching guidance on CIMH implementation, CIMH program, and the mission of the CIMH program. The CIMH Advisory Body will make recommendations concerning the model, standards, and scope of services for the CIMH model to ensure licensure law is not violated, and that all applicable clinical and community partners are working together, at the top of their licensure and capabilities, to coordinate and deliver affordable, meaningful and quality health care.*

Comment: CIMH does not appear to be fully integrated with other reform initiatives, including the Medicaid waiver. CIMH governance structure aligns with the waiver to guarantee consistency and transparency.

Response: *The oversight and governance of these coordinated efforts is a necessity to ensure the successful implementation of CIMH.*

Comment: The Innovation Plan is not clear regarding the use of HSCRC Medicaid Waiver workgroups.

Response: *The CIMH Advisory Body, as part of a larger effort to coordinate delivery and payment reform models across the state, will work with the Department, HSCRC and its Waiver workgroups, and MHCC including its PMCH workgroup, to coordinate and minimize duplication of effort and maximize the benefit of each of its respective initiatives.*

Comment: The Innovation Plan does not address the five year end date of the Medicaid Waiver and how CIMH will have synergy with this from the start.

Response: *By 2017, Maryland as part of the Medicare Waiver will be required to submit to CMS a plan to move away from hospital-focused success tests (e.g. reductions in hospital-acquired conditions) to a total cost of care success test. SIM will allow us to test the CIMH model and bring it to statewide scale so that Maryland is ready when that total cost of care success test is imposed.*

Comment: The CIMH Governance Structure chart in the Innovation Plan is siloed; this may lead to similar problems encountered by the Maryland Health Benefit Exchange (MHBE). There should be a central oversight group for all state-based health care reform initiatives.

Response: *The oversight and governance of these coordinated efforts is a necessity to ensure the successful implementation of CIMH to achieve the triple aim. A major component of the CIMH Advisory Body and the groundwork in the Department is to ensure CIMH is compliant with existing law, including governance and authority between and among all respective state entities.*

Comment: The Innovation Plan's description, function and use of the CIMH Advisory Body does not align with HB 1235.

Response: *Chapter 449 of the Acts of 2014 (HB 1235) establishes the CIMH Advisory Body, which provides overarching guidance on CIMH implementation, CIMH program, and the mission of the CIMH program. The Innovation Plan outlines a greater role for the CIMH Advisory Body as a proposal. The exact function and responsibilities of the CIMH Advisory Body will be determined, as required by HB 1235, and any subsequent recommendations will be included in the pilot and establishment of the CIMH.*

Comment: Patient safety is subordinated to cost considerations in the Innovation Plan. Statements in the Innovation Plan regarding medical reconciliation and adherence monitoring are inconsistent with national standards of care and guidelines.

Response: *Patient safety and improved health outcomes are a key foundation of CIMH in achieving the triple aim of increasing the quality of health care, reducing the cost of health care and increasing patient satisfaction. The state recognizes the need to clearly and adequately address scope of work issues among all clinical and non-clinical parties involved.*

Comment: Research and development (R & D) trials as outlined in the Innovation Plan breach existing scope of practice laws and compromise patient safety.

Response: *Any R & D work through the CIMH will address scope of practice laws with each respective board prior to implementation.*

Comment: The Innovation Plan does not consider a realistic time frame regarding the associated statutory and regulatory steps needed to implement CIMH, Public Utility, operational management and RFP.

Response: *The time frame for implementation will be a critical component of the work required by Chapter 449 of the Acts of 2014 (HB 1235).*

Comment: CIMH CHHs should be under the Office of Health Care Quality (OHCQ) regulation to ensure patient safety, or another single existing jurisdiction.

Response: *OHCQ regulates and ensures the quality of health care in Maryland. The legal aspects of how the CHHs will fall under the purview of OHCQ are an aspect of CIMH development to be addressed by the CIMH Advisory Body and the State*.

TOPIC 12: HEALTH DISPARITIES AND CULTURAL COMPETENCY

Comment: The Innovation Plan does a good job of describing the data systems in Maryland and identifying most key roles and uses of data for the project. However, there is no explicit mention of the need to collect data by race and ethnicity, and to analyze the quality and health outcome measures in strata of race and ethnicity. The Innovation Plan as written seems to underestimate Maryland's minority population. There is also no recognition of the high cost of racial and ethnic health disparities in the State.

Response: *SHIP is both an approach to improving health outcomes at state and local levels and a robust public health measurement system which aims to improve population health and reduce disparities by catalyzing and aligning local action on key dimensions of population health. Under SHIP the State has introduced 41 measures of population health pegged to Healthy People 2020 goals. These measures are presented at the state and county levels and disaggregated by race and ethnicity where possible.*

Comment: Inclusion of cultural competency training in the CIMH proposal to support the provision of culturally competent care.

Response: *The Department agrees. Cultural competency is a core competency for the CHWs who will have a key role in the CIMH framework mediating between health providers and the members of diverse communities. In addition, the Department will continue to explore how to educate providers and community health teams using the PRIMER on cultural competency and health literacy, a guide for teaching health professionals and students (see http://dhmh.maryland.gov/mhhd/CCHLP/SitePages/Download.aspx).*

Comment: The Department should form a Health Equity Workgroup under the SIM Project to fully develop the integration of community health and that is tasked with creating and integrating a theme of racial and ethnic health equity with principles and operational specifics.

Response: *Further input into the CIMH framework will be obtained through the CIMH Advisory Body, which was authorized and established pursuant to Chapter 449 of the Acts of 2014 (HB 1235).*

TOPIC 13: HEALTH INFORMATION TECHNOLOGY AND DATA

Comment: Expanding the IT infrastructure is beyond the scope of the government. It will require incremental steps by providers to maximize the use and interoperability of electronic health records (EHRs) as well as coordination with existing data resources.

Response: *The Department agrees that the government cannot expand the state's IT infrastructure in isolation. Incremental steps will be required, and the infrastructure must be useful to end users, including – but not limited to – providers. However, we believe the government has a critical role to play in shaping the development of the IT infrastructure (e.g. developing standards based policy to facilitate interoperability between data systems, including EHRs), and has the ability to achieve economies of scale for costly investments that would be out of reach of most individual organizations There is also a foundation of existing state data systems that can be leveraged and built upon, thus necessitating state-level coordination.*

Comment: Data capture and access to health care data is very difficult and costly for community organizations. We suggest that the development and operations of this infrastructure be financially supported through SIM and other state funding. For example, CHHs are unlikely to have adequate funding to purchase an operational management system (OMS). We suggest that the OMS be supplied to the CHHs and that they be interoperable and secure.

Response: *The Department agrees. To the extent that the CIMH aims to expand the reach of the healthcare system to address social determinants of health through advanced community-clinical linkages, policies need to be developed to enable patient data to flow to the community organizations that will become increasingly engaged in their care. There is also confusion regarding health privacy laws – both federal and state – and what type of data can be shared with whom. To the extent data access barriers have arisen from this confusion, we hope that additional legal resources, policy clarifications, and technical assistance around the implementation of privacy laws will help to remove those barriers where a clear health care justification can be made for the sharing of data and to ensure that the data is shared in a secure manner. To the extent that the cost of IT infrastructure poses a barrier for community organizations, where the state can help realize economies of scale by procuring IT systems for community organizations, we hope to support this with SIM funding.*

Comment: A shared governance structure with clear guidelines about which individuals and institutions can gain access to what level of data will be important.

Response: *The Department agrees.*

Comment: What tools will be available to assess model fidelity?

Response: *The OMS will be the tool to assess model fidelity. There are several software products available for this purpose, and we intend to purchase an OMS that would work well for the CHHs within the CIMH framework through a competitive RFP process.*

Comment: We suggest that consumers be engaged in the selection of models implemented. A strategy for consumer and community education and engagement is integral to the final design.

Response: *The Department agrees and intends to expand the number of consumer advocates on the CIMH Advisory Body. Through the CIMH Advisory Body, we will also develop a consumer and community education and engagement strategy to ensure that patients understand the model, to provide them an opportunity to provide input into the model, and to ensure that the model is working for them as implementation unfolds.*

Comment: Chesapeake Regional Information System for our Patients (CRISP) data does not provide a complete picture of an individual's health care utilization.

Response: *The Department agrees. That is why we have proposed the use – and expansion of – multiple other data systems, including existing data systems like the all-payer claims database and public health surveillance data, as well as the development of new capacities like PopHealth (for outpatient clinical care data stored in EHRs) and the capacity to link health data with non-health data like social services and education data.*

Comment: How will the MHBE be leveraged to interact with enrollees with respect to their care?

Response: *The provider index developed as part of the MHBE will be an important asset that may be used to attribute patients to PCPs. Principles of value-based insurance design will also be incorporated into the design of qualified health plans available through the MHBE, removing financial barriers to obtaining cost-effective services.*

Comment: The Innovation Plan references several existing data systems but leaves out others (e.g. Children's Electronic Social Services Information Exchange system). The data systems should be interoperable between providers, care coordinators, and care management entities. Connectivity with Wraparound Team Management System should also be enabled.

Response: *The Department agrees that systems should be interoperable between all providers involved in the care of shared patients. We are interested to learn more about any data systems that contain information that will be critical to meet the needs of patients who participate in the CIMH.*

Comment: It will be very important to minimize reporting burden for physician practices and to carefully craft the messaging around quality measurement. With that in mind, technical assistance will be needed around pulling data for performance measurement.

Response: *The Department agrees. Developing a core set of metrics was a major goal of the SIM Model Design process. The four major criteria for measure selection are:*

- *Minimal administrative burden for provider reporting*
- *Utilize metrics already being reported*
- *Endorsed by national consensus organization*
- *Linked to evidence and Meaningful for Maryland*

Based on these criteria, several candidate metrics were identified (though consensus was not achieved). The Department will continue to work with the CIMH Advisory Body and the payers in the State to reach a consensus on the core set of metrics and the staging of those metrics.

Comment: It is advisable to roll out the PopHealth open source software service in stages: an early successful roll-out will help gain the engagement of many physician practices.

Response: *The Department agrees.*

Comment: How will the measures be used and for what purposes? Will there be an opportunity for providers to preview their results (like the 30 day preview cycle that CMS uses)?

Response: *The measures will be used to assess provider performance and to provide providers feedback on their performance. Ensuring the validity and integrity of the data is critical, particularly in the early stages of calculating the claims-based and CRISP-based metrics. Provider feedback on any data irregularities will be very helpful in assuring the quality of the data and giving providers and consumer confidence in the validity of the measures.*

Comment: How will CHHs be notified of who their super-utilizers are in their area? What reports will be sent by the state to the CHH so the CHH can begin planning and outreach? What data will be made available to the CHHs? For example, will CHHs be able to access CRISP's electronic notification system (ENS)?

Response: *We envision that super-utilizers will be identified in one of three ways: (1) CRISP-generated list of patients with three or more hospitalizations in the prior year will be provided to CHHs, along with their PCPs of record; (2) CHHs will receive real-time alerts when patients show up to the emergency room or to the hospital more than one time in the prior 6 months; and (3) PCPs or other providers can refer patients to CHHs if they believe those patients would benefit from CHH services.*

TOPIC 14: IMPLEMENTATION

Comment: The Innovation Plan seems to treat current well established efforts as if they did not exist and proposes to start from scratch.

Response: *The Department's aim is to build upon existing efforts. Because there are many innovative delivery and payment reform efforts underway in Maryland, the CIMH is put forward as a framework within which to better coordinate existing and effective programs. The LS described in the Innovation Plan will enable prompt and rigorous evaluation of these programs to identify those that are most effective and ought to be scaled up.*

Comment: The requirements are not stated specifically enough to know what the practical implementation may mean or yield.

Response: *Per CMS instructions, the Innovation Plan is meant to be ambitious and high-level and present a vision for what a transformed health care delivery system might look like in Maryland given the current state of the health care system and the more pressing health needs.*

Comment: The extent to which assessment tools can be cross-walked and streamlined/standardized prior to implementation will assist in data analysis as well as in serving as communication tools for care coordinators and providers.

Response: *The Department agrees.*

Comment: There are a number of activities that need to occur before the CIMH program is fully operationalized, such as creation of the PCMH minimum standards, expansion of PCMH participation, development of CHW training, etc. How will all of these prerequisites affect implementation? When will CHH RFP be released? And what will be the start date?

Response: *The anticipated notice of cooperative agreement announcement date is October 31, 2014. There is a pre-implementation period of up to 12 months from January 1, 2015 to December 31, 2015 and the anticipated cooperative agreement period of performance will be from January 1, 2016 to December 31, 2018. Therefore, the CHH RFP will be released and awarded some time during the pre-implementation period during calendar year 2015.*

TOPIC 15: INSURANCE

Comment: The current and future role of MCOs as a partner to achieve the "Triple Aim" is not fully accounted for in the report.

Response: *The driver diagram of the SIM report will be updated to include insurers as a partner in achieving the "Triple Aim."*

Comment: The Public Utility would impose burdensome changes on and create redundancies within the insurance marketplace.

Response: *Through the CIMH Advisory Body, the Public Utility and its governance will be defined. The CIMH Advisory Body will be sure to address any changes that could be burdensome and/or create redundancies in the insurance marketplace.*

Comment: The governance structure of the Public Utility is inadequate to protect the public interest and lacks checks on executive authority.

Response: *Through the CIMH Advisory Body, the Public Utility and its governance will be defined to ensure the public's interest is protected and that appropriate checks on authority are in place.*

Comment: Medical homes and other payment reforms are achievable only when providers and carriers are in network relationships. The Innovation Plan should recognize that in network relationships among providers and insurance carriers are essential to achieving the quality, care coordination and financial goals set forth by state policymakers.

Response: *The Department agrees that the relationship described is key to the primary care side of the CIMH model (the blue side of the Venn diagram), but to effectively provide care for individuals with complex health needs, the service delivery model for community health (i.e. the green side of the Venn diagram) extends beyond the provider/carrier relationship. The SIM envisions a truly integrated care*

system that includes somatic and BH providers as well as other community and social services that are not typically part of a carrier network.

Comment: A single PCMH is insufficient and could stifle innovation within marketplace carriers.

Response: *Maryland will implement a set of flexible standards that will allow for a much larger and more diverse set of PCPs to participate in advanced primary care models. This approach will be inclusive of all existing standards currently in use in Maryland in order to minimize disruption to ongoing PCMH efforts. We believe this flexibility will encourage innovation and broaden participation by PCPs.*

Comment: The Department needs to clarify within the Innovation Plan that programs like the Cigna Collaborative Accountable Care Program will be allowed to continue without the imposition of mandated performance standards or mandated payment models. Without this flexibility, the Innovation Plan could stifle innovation within the marketplace as carriers and providers would be unable to determine the nature of their own contractual relationships.

Response: *The proposed standards are intended to provide a meaningful floor, which most advanced primary care models like ACOs and PCMHs already exceed. On the primary care side, payment models will be left to payers and providers to negotiate directly. However, a core set of performance measures is envisioned to reduce reporting burden on providers and enable an apples-to-apples comparison between different advanced primary care models.*

TOPIC 16: INTEGRATION

Comment: The success of CIMH will require consideration of how CIMH will leverage and integrate with other health delivery system reform initiatives, such as the Medicare All-Payer Model, HEZ program, BH integration and long term care reform efforts, as well as the continued efforts to implement the Affordable Care Act.

Response: *The CIMH is not a new "intervention," per se. Rather, it is best conceived of as a flexible model of care or a framework that will enable Maryland to coordinate, refine, and expand services, supports, and delivery reform efforts – many of which already exist in Maryland – so that they can build upon each other and create the synergies required to realize their full potential impact.*

To integrate with existing delivery reform efforts, the Department will continue to engage stakeholders at the state and local level through existing or newly created advisory committees and workgroups. The CIMH Advisory Body, as part of a larger effort to coordinate delivery and payment reform models across the state, will work with the Department, HSCRC, and MHCC to coordinate these workgroups and collection, analytics and data sharing, as well as minimizing the duplication of effort and maximizing the benefit of initiatives.

Comment: We recommend the inclusion of BH clinicians in the CHTs. If the CHT are to include screening and treatment of early stage substance use disorders, clinical social workers and psychologists as well as substance abuse treatment providers will be required to operationalize the CHT.

Response: *Through the CIMH framework the deployment of the CHT will be based on the need of the population to be served by the CHH. The target populations served by the CHH and the services they will*

ultimately determine the full staffing pattern at each CHH. In the case where BH is identified as a need in the population, the CHH would staff the CHT appropriately.

Comment: The Innovation Plan speaks of integration but the focus is largely from a public health and physical health perspective. There did not appear to be examples of integration with primary BH.

Response: *The Innovation Plan lists the critical CIMH goals and includes the integration of somatic and BH care services. Because Maryland faces a shortage of BH providers, the Innovation Plan emphasizes that BH issues are addressed in primary care settings whenever possible. Also, because physical conditions are often co-morbid with BH conditions, treatment in primary care settings will enable more effective care coordination.*

Comment: We are extremely pleased that the Innovation Plan expands the Chronic Health Home initiative currently in its first year of implementation. To achieve full integration of somatic and BH care it is recommended that the Department carefully review what is needed for the Chronic Health Home to become full "medical" homes. This would allow for patients that receive care in Chronic Health Homes to have both somatic and BH needs met.

Response: *The CIMH framework supports more fully integrated somatic and BH to provide patients the most comprehensive health care services.*

Comment: In regard to primary care and BH integration, it is critical to provide appropriate training and support to PCPs.

Response: *The Department agrees. Under the CIMH, the existing Behavioral Health in Pediatric Primary Care Program (BHIPP), which currently targets youth, will be expanded to provide consultation for adults. It is anticipated that continued implementation of BHIPP in CIMH will lead to significant improvements in access to mental health care and improvements in adult's mental health.*

TOPIC 17: LOCAL HEALTH IMPROVEMENT COALITIONS AND LOCAL HEALTH DEPARTMENTS

Comment: There are concerns about mandatory statewide charters or regulations that would decide the organizational structure, governance, or function of these local products (i.e. LHICs). The dynamics of different jurisdictions and LHICs in Maryland suggest that "one size fits all" approach to LHICs would endanger the success and long term viability of these locally driven partnerships. LHDs are the local health planning authority unless another body is designated as such by the LHO according to statute. LHICs were convened by LHDs to collaborate with partners on achieving population health outcomes, they were not intended to be bodies that would independently duplicate the essential public health services already charged to LHDs. We recommend that the Department identify ways to strength Maryland's existing local public health infrastructure and leadership, rather than inadvertently creating a conflict and duplication.

Response: *The Department agrees that a "one size fits all" approach will not work. The Department and 24 LHDs will continue to carry out traditional public health work around the three core functions of public health and the 10 essential services. The 20 LHICs spanning the entire state have been providing the framework for accountability and continual progress toward a healthier Maryland. As such, the LHIC will continue to be the entity in the community chiefly responsible for convening stakeholders, planning, prioritizing, aligning strategies, and tracking population health outcomes. The LHIC will also be*

responsible for having a comprehensive and up-to-date inventory of resources, services and current contacts for the CHH to access in coordinating care for their patients. Because the LHO is typically a co-chair of the LHIC, LHDs will continue to be very much involved in the LHIC functions.

Comment: We recommend that LHOs should control CHH funding in their communities through an RFP process.

Response: *A LHD will be eligible to apply to be a CHH. If selected to be a CHH, the LHO would control the funding for the community served by the CHH.*

Comment: The LHICs should be connected to and coordinated with the work of the Local Management Boards (LMBs) as well as the local Core Service Agencies (CSAs), which are local public mental health authorities.

Response: *LHICs have been established across the state and bring together public health, health care, and other community leaders to identify their community's priority health needs and develop local health improvement action plans to address them in collaborative ways that would not be possible if each partner acted in isolation. In some jurisdictions, partners include LMBs and CSAs as well as any other existing entities that are critical to health care planning.*

Comment: A big variable in the model may be the strength of the individual LHICs. The strong ones will need little help and yet some will need guidance and intense support to get them engaged, truly operational, and productive.

Response: *The CIMH model will strengthen Maryland's community health infrastructure by identifying best practices from the most effective LHICs, which are characterized by a history of working closely and productively with their public health partners as well as their hospital health system, PCPs, BH, school systems, and social services. Using these best practices, each LHIC will be supported in developing a LHIC Charter to further define the key elements of an effective LHIC in the areas of governance, leadership, stakeholder engagement, operations, and accountability. Through these efforts, the Department will help to raise the tide for all LHICs and narrow the gap between the more robust and developed LHICs and those that have only recently formed.*

Comment: In "Strategy A: A Foundation of Effective Public Health and Primary Prevention" it is noted that the Department will pursue accreditation and that "the Department also remains committed in its support of LHDs in their own pursuit of voluntary accreditation." Please clarify what support means. Would this include financial support?

Response: *The Department continues to provide guidance and technical assistance support to LHDs in their pursuit of public health accreditation. Examples of ongoing support include responding to accreditation requests of a LHD, providing documentation to a LHD, and convening LHOs on mutual support calls to support sharing of learning and best practices across jurisdictions.*

Comment: The State has hosted several stakeholder meetings from May 9, 2013 through September 10, 2013, and crafted legislation specific to CIMH. Has the State designed a plan to reach-out and educate a "target community" on the specifics of the model or will that responsibility rest on the LHICs/CHHs?

***Response**: The Department proposes to develop, in concert with these other initiatives, a consumer education and engagement campaign. Within the larger message we propose to develop a targeted education campaign on the specific elements of the CIMH model that are the keys to its success.*

TOPIC 18: MARYLAND ACCESS POINT

Comment: Maryland Access Point (MAP) is an essential part of SIM. MAP is the gateway through which individuals will enter to access Medicaid community long term care programs such as Community First Choice and the Community Options Waiver. MAP and the Area Agency on Aging Network should be an integral part of SIM and SIM will be improved by adding MAP because: MAP is a local, transparent, and trusted entry point for individuals seeking long time care services in the community; MAP staff already serve as social service navigators for individuals with long term care needs, including for care transitions. Through the Living Well/Chronic Disease Self-Management Program, the Maryland Department of Aging has developed a robust, evidence-based self-management program through the state which is proven to positively impact the triple aim, develop partnerships with hospital CHHs, and develop a model for CHW integration.

***Response:** While the scope of the CHH services will be broader than those of the Medicaid population, MAP's strengths could allow it to become a valuable partner to CHHs under SIM. Maryland is seeking to retain and foster effective partnerships in implementing SIM.*

TOPIC 19: MEASURES AND REPORTING

Comment: Quality metrics do not fully align to the HealthChoice program measures, such as National Committee for Quality Assurance (NCQA), HealthChoice Report Card, Healthcare Effectiveness Data and Information Set (HEDIS) or value based purchasing for which MCO's are already at financial risk. A greater understanding of the Medicaid Quality Program and alignment of the measures would be preferred.

***Response:** Developing a core set of metrics was a major goal of the SIM Model Design process. The four major criteria for measure selection are:*

- *Minimal administrative burden for provider reporting*
- *Utilize metrics already being reported*
- *Endorsed by national consensus organization*
- *Linked to evidence and Meaningful for Maryland*

Based on these criteria, several candidate metrics were identified. We did consider HealthChoice and HEDIS in developing the measure set. Since consensus was not achieved, the Department will continue to work with the Advisory Body and the payers in the State to reach a consensus on the core set of metrics, explore ways to facilitate greater alignment and the staging of those metrics that are ultimately selected.

Comment: There are some specific measures for children and, in particular. However, particularly under mental health, the measures are lacking.

***Response**: The Department agrees and will consider all measures that meet the measure inclusion criteria.*

Comment: For measures of success, we recommend that under the section on Mental Health and Substance Abuse, the column for children should include category for Initiation and engagement in substance use disorder education and treatment. It must be recognized that children and adolescents are engaging in substance use and treatment is most effective when treated and addressed early. There should also be categories for screening of childhood depression and mental health disorders other than attention deficit hyperactivity disorder (ADHD).

Response: *The Department agrees and will consider all measures that meet the measure inclusion criteria.*

Comment: Although mental health screening and assessment and counseling for behavior change is noted as a screening measure, there is no specific reference to SBIRT or any other substance use screening except interventions to quit smoking. SUDs screening should be added to this chart as an intervention to be utilized by community providers.

Response: *The Department will consider all measures that meet the measure inclusion criteria. At this time, we are not aware of screening metrics that are in wide use and have been endorsed by a consensus setting organization like the NQF. If these metrics exist, we would be interested to learn more.*

Comment: There should also be categories for screening of childhood depression and mental health disorders other than ADHD.

Response: *The Department will consider all measures that meet the measure inclusion criteria.*

Comment: When can CHHs anticipate a more complete or finalized list of measures and will this list be provided prior to the approval of the CIMH testing phase?

Response: *Developing a core set of metrics was a major goal of the SIM Model Design process. The four major criteria for measure selection are:*

- *Minimal administrative burden for provider reporting*
- *Utilize metrics already being reported*
- *Endorsed by national consensus organization*
- *Linked to evidence and Meaningful for Maryland*

Based on these criteria, several candidate metrics were identified (though consensus was not achieved). The Department will continue to work with the CIMH Advisory Body and the payers in the State to reach a consensus on the core set of metrics and the staging of those metrics. Yes, a finalized list of measures will be provided before approval of the CIMH testing phase.

TOPIC 20: ORAL HEALTH

Comment: The concept of community-integrated care is worthwhile. However, the Innovation Plan does not address the need for improved oral health outcomes and access to dental services. As development of the model moves forward, it is critical to incorporate dental services because there is a strong link between oral health and systemic diseases.

Response: *Access to dental care is a measure of success for the SHIP as well as a proposed quality metric.*

Comment: In no part of the CIMH is there mention of inclusion of dental services. We recommend dental services be included in the PCMH model as it has significant impact on children's health.

Response: *Access to dental care is a measure of success for SHIP as well as a proposed quality metric.*

TOPIC 21: PATIENT CENTERED MEDICAL HOME

Comment: There is significant amount of work to do to have FQHCs really put the systems in place for interdisciplinary team care and disease management and be successful PCMHs.

Response: *FQHCs will be expanded and strengthened by the CIMH model. Maryland's PCMH/CIMH program flexibility and lightened burden to participate is the incentive for participation while recognizing practices currently participating in a PCMH program. Also, by its nature, the CHH allows providers to focus on clinical activities necessary to achieve good patient outcomes.*

Comment: How do statements "Moving forward, Maryland's approach to certification will be flexible…" affect existing PCMH and Health Home Models? The statements seem to blend the CIMH and PCMH programs together, yet there is no information about how these programs will be merged.

Response: *The CIMH is an expansion of the PCMH when CHH services are offered in collaboration with PCMH care to meet patient needs.*

Comment: The ongoing governance of the PCHM models is not clear. Will the CIMH Advisory Body advise the MHCC on the structure of the PCMH program? Who will have ultimate authority for the PCMH program? Will it be the Department or MHCC?

Response: *Pursuant to Chapter 449 of the Acts of 2014 (HB 1235), the CIMH Advisory Body was established to provide overarching guidance on CIMH implementation, including governance. The CIMH is an expansion of the PCMH when CHH services are offered in collaboration with PCMH care to meet patient needs. The authority to approve a PCMH will still reside with MHCC.*

Comment: The 15 Medicare ACOs currently approved to operate in the State-all under different models deemed to be certified; however, no such assurance is given to existing successful single carrier PCHM programs.

Response: *Yes, they will be deemed certified.*

Comment: The Innovation Plan notes that there are core PCMH principles necessary for success and treats these as a given, even while there is little in the existing literature to prove that these principles or standards result in better outcomes. A more logical statewide approach would be to allow different models to operate and test criteria, with flexibility for the model to change course as experience dictates, rather than stifle innovation.

Response: *The Department agrees**.** This flexibility is a hallmark of the Innovation plan. While a meaningful floor will be defined through state standards, any model that meets that minimum standard will be deemed a PCMH. This variability will then be evaluated through the LS to identify which set of standards most predictably leads to better outcomes and lower cost.*

Comment: Is it the State's intention that the CHH's activities would focus exclusively on PCMH's that meet the new minimum standards? Many super-utilizers may not be connected with a PCMH or they may be connected to a PCMH that does not meet the minimum standards. Will the CHH serve these individuals?

Response: *Yes the CHH will serve these individuals. There are many sources from which a CHH will be able to accept referrals, including hospitals and other primary care sites not yet deemed a PCMH. Patients who are high-utilizers who need a CHH are presumed to also need a PCMH. Patients identified by hospitals, etc as needing CHH services will be encouraged/assisted to identify and utilize a PCMH.*

Comment: Lack of provider support will result in low PCP participation rates. When describing the provider the Innovation Plan mentions intensive work for the participating provider, yet there is no definite funding support envisioned for the provider. There are substantial data collection and submission requirements but there is no consideration of support for providers to meet these requirements, unclear liability protections, and unclear certification standards.

Response: *The intent of the CIMH is to help PCPs shoulder their responsibilities for caring for super-utilizers by providing the wraparound services and supports that a PCP would have difficulty providing (e.g. home environmental remediation services) but are necessary for optimal patient help. Additionally, the data infrastructure will be expanded precisely to minimize the reporting burden placed on providers. Of the 35 measures proposed, the Department will continue to work with the CIMH Advisory Body and the payers in the State to reach a consensus on the core set of metrics and the staging of those metrics so that all the metrics could be calculated for providers using claims data and data available via CRISP, thus imposing no reporting burden on providers.*

Comment: "Basic PCHM design features may be just as likely to result in improvements as highly structured national standards" does this mean that the MHCC and carriers are going to move away from NCQA certification requirements?

Response: *Maryland's PCMH/CIMH program will be flexible and result in a lightened burden to participate and will be inclusive of many current standards.*

Comment: Instead of supporting current PCMH models, the plan proposes to create a single set of PCMH standards that would cover all programs. While the plan indicates that the new program would be inclusive of the standards used in current programs, the criteria listed do not make this clear.

Response: *Yes, standards will be inclusive of many current standards.*

Comment: The plan outlines the standardization of PCMH elements ranging from accreditation requirements to quality standards and all other underlying methods to implement these programs, with no recognition of how this effort would be informed by the operation of current, successful single carrier PCMH programs.

Response: *The standards are intended to be a meaningful floor, PCMH programs are likely to meet or exceed. The purpose of the flexible standards in a LS is that we will be able to learn from the variation, including from the experience of current single carrier PCMH programs, and learn which set of standards is most predictive of higher outcomes and lower costs.*

Comment: The CIMH proposal, in an effort to encourage more PCPs to participate in the PCMH program, may not require that they undertake the same certification process required of current PCMHs. The certification standards were established to ensure that consumer safety and receipt of quality care.

Response: *The evidence suggests that current PCMH standards do not yield better health outcomes or result in improved patient safety. Thus these new standards create a meaningful floor that will, in addition, permit many more providers to participate in advanced primary care models. Maryland's PCMH/CIMH program will be flexible and result in a lightened burden to participate and will be inclusive of many current standards. The LS will assist in determining which standards are most valuable to improve outcomes and lower cost.*

Comment: Reducing the hassle for physician practices while retaining successful elements of the PCMH model as described in the SIM flexible PCMH model will likely be embraced by physician practices. For small primary care practices with minimal small staff, full PCMH accreditation is onerous. Primary care practices rarely shut down their schedules for offsite training, but webinars, remote coaching or on-site technical assistance that can be integrated during the work day is accepted.

Response: *The Department agrees. Therefore, the Department has proposed a flexible set of PCMH standards with a meaningful floor that does not create undue burden on providers.*

Comment: The proposed model of testing interventions for a 2-year period then expecting sustainability for year 3 and beyond, seems overly ambitious to expect meaningful outcomes in a short time frame (2-3 years) for remediation of the effects of the major and intractable social determinants of health, and perhaps underestimates the cost of such remediation.

Response: *It is anticipated the SIM dollars will be sufficient to fund the first 3 years of the CIMH program. Based on the chosen target population and the models used to inform the design of the CIMH model, the anticipated ROI will make the program sustainable.*

Comment: Lack of funding and support for providers will lower participation by providers.

Response: *Maryland's PCMH/CIMH program will be flexible and lighten the burden to participate which will be an incentive for participation by new provider while recognizing practices currently participating in a PCMH program.*

Comment: It is great that the Innovation Plan includes a focus on Screening, Brief Intervention, and Referral to Treatment (SBIRT) in PCMHs, particularly for Quadrants III and IV patients. However, SBIRT is not treatment for substance use disorders as the Innovation Plan perhaps might seem to imply. Rather, SBIRT is a systematic way of identifying individuals with harmful levels of use that have not yet reached DSM-V diagnostic criteria for SUDs, and provides interventions that can help prevent further progression to such conditions. While SBIRT is an important tool, having it form the basis of substance use treatment, even in these low BH need categories, is confusing and misses the importance of treatment for moderate to severe SUDs.

Response: *The Department agrees, we will clarify this in the Innovation Plan.*

Comment: Currently, Chronic Health Home status is only available to providers who are licensed Methadone providers. We recommend that all SUD providers be eligible to be CHHs.

Response: *At this point, the Department does not intend to expand the eligibility criteria for providers to become Medicaid Chronic Health Homes. Medicaid enrollees with BH needs who are in need of enhanced services and are not seen by a Medicaid Chronic Health Home provider will be referred to the CIMH under the SIM.*

Additionally, the Department is proposing to have a Medicaid ACO coordinate the care of individuals who are eligible for both Medicaid and Medicare. Many of these individuals will have BH needs.

TOPIC 22: PRIVACY

Comment: The plan needs a stronger emphasis on patient choice and privacy, including: informed consent; robust security infrastructure/protections; routine and ongoing data sharing; Health Insurance Portability and Accountability Act; patient pressure or requirements to share data under the new model; protections for sensitive health information; and/or protections for historically underserved or marginalized groups.

Response: *The Department agrees. SIM anticipates developing a process by which the public would be informed about the new delivery system and data sharing. As part of that public education, we anticipate working with the Attorney General and providers to develop an informed consent process that fully describes the confidentiality protections and consumer complaint process.*

Comment: The Innovation Plan anticipates unprecedented data sharing between state and local agencies and health care providers. How will consumers be informed about the scope of data collection? Will a Privacy Impact Assessment be conducted? How will consumer complaints be addressed and resolved?

Response: *The Department agrees. A Privacy Impact Assessment should be conducted and there should be a process designated for resolving consumer complaints.*

TOPIC 23: SCHOOL-BASED HEALTH CENTERS

Comment: How will the Department support the fiscal and programmatic expansion of School-Based Health Centers (SBHCs) capacity into CIMHs? How will the Department evaluate expanding the patient bases of SBHCs?

Response: *The Public Utility will assist SBHCs in expanding their programmatic capabilities by sharing health measures among different types of care providers, state agencies, and social service systems.*

Comment: Will every school in every county have a SBHC prior to implementing CIMHs? Will every SBHC become a CIMH?

Response: *No, not every school in every jurisdiction will have a SBHC prior to implementing CIMH. The needs of the community and readiness of providers will guide the development of CIMHs.*

TOPIC 24: SOCIAL DETERMINANTS OF HEALTH

Comment: It is of concern that the Innovation Plan focuses on the social determinants of health to test initiatives that can be "brought to statewide scale under the total cost of the modernized hospital waiver," and that the Innovation Plan may be underestimating the tenacity of social determinants of health and therefore the necessary time and money needed to address them.

Response: *It is anticipated the SIM dollars will be sufficient to fund the first 3 years of the program, and based on the chosen target population and the models used to inform the design of the CIMH model, the anticipated ROI will make the program sustainable.*

Comment: We urge the State to recognize the deep seeded nature of the social determinants of health, and as such, to not limit hospitals to community partnerships to address these issues. Allow us the latitude to design a portfolio of the most efficient and targeted hospital-based programs and community collaborations to provide better health at a lower cost.

Response: *The Innovation Plan does provide for this flexibility. The CIMH is meant to provide the robust primary care and community health infrastructure to keep patients healthy and out of the hospital when they can be more effectively cared for in outpatient and community settings.*

TOPIC 25: TARGET POPULATIONS

Comment: The narrowness of eligibility criteria risks losing the full benefit of an integrated community approach. In targeting super-utilizers, it does not focus enough on keeping the healthy segment healthy.

Response: *Strategy A is intended to address the needs of the healthy through primary prevention and traditional public health. Those services and supports will continue and be strengthened under SIM through efforts like public health accreditation and the monitoring of uptake of preventive services graded A or B by the United States Preventive Services Task Force.*

Comment: The "reduce ER visits related to mental health conditions" measure in the Innovation Plan is listed as "updated measure is not moving toward the Maryland 2014 Target."

Response: *The Department agrees. Based on our most current data, statewide progress on improving this particular SHIP measure is not advancing as quickly as we would like. For this reason, BH has been a focus of the SHIP. Through efforts like CIMH and the new Medicare waiver, our hope is that we will be able to make progress on this measure.*

Comment: The Innovation Plan does not adequately discuss the changes that have been made in Medicaid long term care to improve care coordination/collaboration under the Community First Choice and Combined Options waivers.

Response: *Community First Choice provides supports to older adults and those with disabilities so they can remain in their own home. Community First Choice and other similar programs, which divert from institutional placement and toward home and community-based services, should be built upon to reach the "Triple Aim." These waiver programs include continuous case management; such case management providers could become part of the CHT deployed by the CHHs under SIM.*

TOPIC 26: WORKFORCE DEVELOPMENT AND TRAINING

Comment: The Innovation Plan does not address workforce development and support of multidisciplinary health teams that are needed to increase success of new innovative programs in diverse communities.

Response: *The Department agrees. One aspect of applied R & D that we will pursue is to thoughtfully experiment with adjusting workforce roles, in particular greater use of CHWs and their role in multidisciplinary health teams.*

Comment: How and who will set the educational standards for the CHW training and certification as well as the cost for the training program? How will these educational standards for CHW fit with current specifications of the Department of Budget and Management, hospitals or primary care practices?

Response: *Pursuant to Chapter 259 of the Acts of 2014 (HB 856), the Department and MIA are required to establish the CHW Workgroup to study and make recommendations regarding the training and credentialing for CHWs and reimbursement and payment policies for CHWs through the Maryland Medical Assistance Program. These recommendations will be reported to the Maryland General Assembly by June 1, 2015.*

Comment: Has a practice model for care coordination been identified? Will it be patient/family driven? Include a team of people? Will it function more like case management vs team-based planning? Will the model vary based upon populations?

Response: *The CHW may be utilized in a number of ways in the CIMH model. They may be embedded in care teams within a primary care practice or as part of the CHH CHT and work primarily as a trusted member of both the care team and the community to support individual engagement with CHT and the PCPs.*

Comment: In the discussion of the "*Goal: BH Integration with Primary Care*," the focus is primarily on collaboration with mental health providers and PCPs. SUD providers should be included in the training of PCPs and in consultation and collaboration with plans. PCPs should be trained in SBIRT and referrals should be made to SUD providers when appropriate.

Response: *The Department agrees.*

TOPIC 27: WRAPAROUND SERVICES

Comment: The term "wraparound" is a practice model used to serve children with serious BH needs and their families as recognized by the CMS and the Substance Abuse and Mental Health Services Administration. The term "comprehensive" may be more appropriate than "wraparound" to describe the activities in Strategy C.

Response: *The term "wraparound" in the Innovation Plan is used broadly in the CIMH framework to describe the functions of CIMH CHTs that will provide complementary public health and comprehensive community-based services and supports to PCPs and their most vulnerable patients.*

TOPIC 28: OTHER COMMENTS

Comment: Are environmental interventions included as part of the "24 evidence-based services" in the example of the community-integrated approach to asthma?

Response: *Yes, the evidence base is clear that home environmental assessment and remediation is critical in the care of patients with asthma.*

Comment: What is the definition of "BH"? The term should be specified as meaning both mental health and substance use disorders.

Response: *The Department agrees and would like to clarify that by "BH," we mean both mental health and substance use disorders.*

Comment: Improved care for individuals with BH needs is due to a shortage of providers. We fail to see how this proposal will increase mental health service providers.

Response: *A number of initiatives described in the Innovation Plan are designed to address the issue of provider shortages for BH. The evidence suggests that many patients with BH care needs could be seen effectively in primary care settings: this is what is behind the national push towards BH integration in primary care settings (see for example, http://www.integration.samhsa.gov/integrated-care-models). To the extent we can help to raise the comfort level of PCPs to treat low-severity BH patients this will improve the capacity of BH providers to concentrate on those patients with high-severity BH needs. Expanding the BHIPP program will also expand the geographic reach of BH specialists.*

Comment: We suggest that the Innovation Plan be revised to recognize the positive impact that Medicare Advantage plans can have on improving care for dual-eligible and include efforts to enroll more dual eligible in Medicare Advantage plans.

Response: *Medicare Advantage plans can play an important role in coordinating care for dual-eligible and the Department does not discourage enrollment in Medicare Advantage plans.*

Comment: The Innovation Plan seems to rely heavily on schools to improve the health of school-aged children. What about youth outside of schools? (e.g. drop-outs or those expelled or suspended for long periods)? How will they be engaged?

Response: *We believe that for the health of school-aged children, schools are currently overlooked and underutilized as sites of care and health promotion. Our intent was to ensure that schools are well integrated in the CIMH model and can play a significant role in delivery system reform. However, our intention was not to suggest that schools would be the only channel through which we could reach youth. We envision that super-utilizers will be identified in one of three ways: (1) a CRISP-generated list of patients with three or more hospitalizations in the prior year will be provided to CHHs, along with their PCPs of record; (2) CHHs will receive real-time alerts when patients show up to the ER or to the hospital more than one time in the prior 6 months; and (3) PCPs or other providers (including but not limited to school nurses) can refer patients to CHHs if they believe those patients would benefit from CHH services. Youth outside of schools could be engaged in all three ways.*

Comment: With regard to the BH/primary care integration quadrants, who is actually in charge in quadrant I? Can it be either? Also, someone who is lower need with schizophrenia requires very different care than someone who is lower need with depression.

Response: *Yes, we believe that it can be either but that the lead responsibility should be determined based on the patient's most pressing need at any given time, and both somatic and BH providers continue to coordinate efforts with each other regardless of who is "in charge" at the time. Because patients' needs can fluctuate – which somatic needs being more pressing at one time and BH being more pressing at another – we anticipate that the "lead" role will also fluctuate. We also agree that care plans need to be tailored to the meet the needs of the patient.*

Comment: SBIRT may not be enough because evaluation and referral without strong treatment support is not very successful for mental health treatment.

Response: *The Department agrees. SBIRT is one way that we hope to better integrate BH into primary care where that is appropriate.*

Comment: The metrics used in the HQP model are too rigid and may not be appropriate for BH. Qualitative and individualized outcomes are important for patients with severe mental illness.

Response: *We agree and our intention was not to apply the metrics used in the HQP model to patients with serious and persistent mental illness (SPMI). The HQP model focused on elderly Medicare patients with at least one hospitalization and one of five chronic diseases, of which SPMI was not one. The Chronic Health Home metrics are probably more appropriate for the SPMI population and will be used to assess performance.*

Comment: We have already invested significant time and effort in preparation for the SIM/CIMH. Would the Department be willing to allocate start-up funding prior to the approval of the CIMH testing phase under CMMI's SIM Model Test grant?

Response: *At this time, the Department does not have additional resources outside of a possible SIM testing award from CMMI.*

Appendix - Acronyms

ACOs	Accountable Care Organizations
ADHD	Attention Deficit Hyperactivity Disorder
APS	Advanced Preventive Services
BH	Behavioral Health
BHIPP	Behavioral Health in Pediatric Primary Care Program
BSW	Bachelor's Degree in Social Work
CHHs	Community Health Hubs
CHTs	Community Health Teams
CHWs	Community Health Workers
CHW Workgroup	Workgroup for Workforce Development for Community Health Workers
CIMH	Community-Integrated Medical Home
CIMH Advisory Body	Community-Integrated Medical Home Advisory Body
CMMI	Centers for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid
CRISP	Chesapeake Regional Information System for our Patients
CSAs	Core Service Agencies
EHRs	Electronic Health Records
ENS	Electronic Notification System
FFS	Fee-for-service
FQHCs	Federally Qualified Health Centers
HB	House Bill
HEDIS	Healthcare Effectiveness Data and Information Set
HEZ	Health Enterprise Zone
HQPs	Health Quality Partners
HSCRC	Health Services Cost Review Commission
HSIA	Health Systems and Infrastructure Administration
Innovation Plan	State HealthCare Innovation Plan
IT	Information Technology
LHDs	Local Health Departments
LHICs	Local Health Improvement Coalitions
LHOs	Local Health Officers
LMBs	Local Management Boards
LS	Learning System
MAP	Maryland Access Point
MCOs	Managed Care Organizations
MHBE	Maryland Health Benefit Exchange
MHCC	Maryland Health Care Commission
MIA	Maryland Insurance Administration
NCQA	National Committee for Quality Assurance
OHCQ	Office of Health Care Quality
OMS	Operating Management System
PCMHs	Patient Centered Medical Homes
PCPs	Primary Care Providers
RFA	Request for Application

RFP	Request for Proposal
R & D	Research and Development
RNs	Registered Nurses
ROI	Return-on-Investment
SBHCs	School-Based Health Centers
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SHIP	State Health Improvement Process
SIM	State Innovation Model
SPMI	Serious and Persistent Mental Illness
SPA	State Plan Amendment
SUD	Substance Abuse Disorders
The Department	Maryland Department of Health and Mental Hygiene